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## Section 9 - Special Programs

### California Children's Services (CCS)

The CCS program provides health care to children and adolescents from birth to age 21 who have a CCS-eligible medical condition.

The CCS program provides diagnostic and treatment services, medical case management, dental services, and physical and occupational therapy services. The CCS program only authorizes dental services if such services are necessary to treat the beneficiary's CCS-eligible condition. Examples of medical conditions of children who are CCS-eligible include cystic fibrosis, hemophilia, heart disease, cancer, traumatic injuries, handicapping malocclusion, cleft lip/palate, and craniofacial anomalies.

CCS serves approximately 175,000 children who have the following types of program eligibility:

- ◆ **CCS/Medi-Cal:** These beneficiaries are eligible for full scope benefits with no share of cost under Medi-Cal.
- ◆ **CCS-only:** These beneficiaries are children from low-income families, or families whose estimated out-of-pocket expenses exceed 20% of a family's income. They receive health care funded by the State and the counties, and are limited to the treatment of their CCS-eligible conditions.
- ◆ **CCS/Healthy Families:** These beneficiaries have CCS medically eligible conditions and are enrolled in Healthy Families, California's State Children's Health Insurance Program (SCHIP). Treating these beneficiaries' CCS conditions are carved out of the coverage of the Healthy Families health plans and are provided on a fee-for-service basis by the CCS program.

Any individual, including a family member, school staff, public health nurse, doctor, or dentist may refer a child to the CCS program for an evaluation. The referral to the CCS county program or CCS State Regional Office may be made by fax, phone call, correspondence, or the CCS Dental and Orthodontic Client Service Authorization Request (SAR) form (CDHS 4516). CCS will not

cover any services provided prior to the date the referral was received by the CCS program.

### Genetically Handicapped Person's Program (GHPP)

The GHPP is a State-funded program coordinating care and payment for selected dental services of persons over the age of 21 years with eligible genetic conditions. Eligible conditions include, but are not limited to, hereditary bleeding disorders, cystic fibrosis, and hereditary metabolic disorders.

The GHPP program serves adults and certain children who have the following types of program eligibility:

- ◆ **GHPP/Medi-Cal:** These beneficiaries are eligible for full scope benefits with no share of cost under Medi-Cal.
- ◆ **GHPP-only:** These beneficiaries receive comprehensive State-funded health care.

There will be no changes at this time for GHPP-only beneficiaries. Claims for GHPP-authorized services for GHPP-only beneficiaries will continue to be submitted on a CMS 1500 claim form (with the backup documentation on a dental insurance claim form). Providers are to continue submitting claims to the State GHPP program for review and approval. The State GHPP program will forward these claims to Electronic Data System (EDS) for processing. Providers will be notified when future system enhancements will change the GHPP claims processing guidelines.

### CCS-only, and CCS/Healthy Families Beneficiaries Residing in Los Angeles and Sacramento Counties

Until further notice, providers treating CCS-only and CCS/Healthy Families beneficiaries residing in Los Angeles, and Sacramento counties are to continue submitting for payments to the appropriate CCS county program in accordance with the authorization

and claims processing guidelines that currently exist.

#### **CCS-only and CCS/Healthy Families Authorizations and Claims Processing**

To begin the CCS process for dental services, the provider must submit a CCS Dental and Orthodontic Client SAR (CDHS 4516) to the CCS county program. The provider may fax or mail this form to the CCS county program. The CCS county program will review the requested dental services and determine if the patient qualifies for the services based on their CCS-eligible medical condition.

Providers are required to obtain a SAR approval from the CCS county program, or CCS State Regional Office of the beneficiary's county of residence, prior to performing dental services. An approved SAR only authorizes the dental scope of benefits.

The CCS county program will issue a CCS SAR to the provider which will indicate the authorized Service Code Grouping(s) or individual procedure code with a "begin date" and "end date" for up to one year. SARs for orthodontic treatment will be issued for up to two years. If the treatment is completed before the "begin date" or after the "end date" indicated on the SAR, payment will be disallowed.

The approved SAR does not guarantee payment. Payment is always subject to the dental criteria and submission requirements of the Denti-Cal program.

Providers are to adhere to all Denti-Cal policies and TAR/Claim submission requirements. Refer to the Orthodontic Services Program in this section as well as the Manual of Criteria section of this Handbook.

Providers do not have to attach the SAR to the Denti-Cal TAR/Claim. CCS electronically notifies Denti-Cal of providers who have received authorized SARs. If the procedure requested on the TAR/Claim is not on the SAR, payment/ authorization will be disallowed with Adjudication Reason Code 390.

#### **CCS/Medi-Cal and GHPP/Medi-Cal Authorizations and Claims Processing**

Beneficiaries with CCS/Medi-Cal or GHPP/Medi-Cal do not require a CCS SAR.

These beneficiaries have Medi-Cal eligibility and are only case managed by CCS.

CCS/Medi-Cal and GHPP/Medi-Cal claim/ TARs are to be sent directly to Denti-Cal. CCS/Medi-Cal beneficiaries requiring dental benefits beyond the scope of the Denti-Cal program may submit a TAR requesting Early and Periodic Screening, Diagnosis, and Treatment-Supplemental Services (EPSDT-SS). Refer to EPSDT-SS in this section.

#### **Orthodontic Services for CCS-only Beneficiaries**

The CCS program has adopted the Denti-Cal orthodontic criteria for children with handicapping malocclusion, cleft lip/palate and craniofacial anomalies. Orthodontic diagnostic and treatment criteria are contained within the Manual of Criteria for Medi-Cal Authorization (Dental Services) in this Handbook.

#### **Providing Orthodontic Services To Denti-Cal Beneficiaries**

In order to provide orthodontic services to Denti-Cal beneficiaries, a provider must be "actively" enrolled in the Denti-Cal program and be enrolled as a Certified Orthodontist. Refer to Enrollment Requirements of this Handbook for additional information regarding enrollment. If the provider is uncertain of his/her current Denti-Cal status, he/she may phone the Denti-Cal Telephone Service Center (800/423-0507) and request an Orthodontic Provider Enrollment Form.

As defined in Title 22, California Code of Regulations, Section 51223(c), a qualified orthodontist is a dentist who confines his/her practice to the specialty of orthodontics and has:

- ◆ Successfully completed a course of advanced study on orthodontics of two years or more in a program recognized by the Council on Dental Education of the American Dental Association, or
- ◆ Completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontics.

### Eligibility

Providers are to request a CCS Service Authorization Request (SAR) from the CCS county program or CCS State Regional Offices for CCS-only and CCS/Healthy Families (CCS/Healthy Families) dental services and then submit TAR/Claim forms to Denti-Cal. CCS/Medi-Cal and GHPP/Medi-Cal claims/TARS are to be sent directly to Denti-Cal and do not require a CCS SAR. Note: CCS SARs are not transferable between dental providers.

Providers are to submit a separate claim for a beneficiary with CCS/Medi-Cal or GHPP/Medi-Cal eligibility and a separate claim for a beneficiary with CCS-only and CCS/Healthy Families eligibility. Submitting separate claims will expedite Medi-Cal reimbursement in the event a county has insufficient funds. If a provider submits one claim with CCS/Medi-Cal benefits or GHPP/Medi-Cal benefits with a CCS-only or CCS/Healthy Families for payment, and the CCS county program/State GHPP program does not have sufficient funds, the provider's entire claim will be withheld until sufficient funds are available.

### Changes in the Beneficiary's Program Eligibility

CCS-only, CCS/Healthy Families, GHPP-only, CCS/Medi-Cal, and GHPP/Medi-Cal beneficiaries are issued California Benefits Identification Cards (BIC). The BIC enables providers to determine eligibility through the AEVS, POS Device, and/or the Medi-Cal Web site: <http://www.medi-cal.ca.gov/>. A beneficiary's program eligibility may change at any time and it is the provider's responsibility to verify eligibility prior to treating the beneficiary.

When the beneficiary changes to the CCS-only or CCS/Healthy Families program, providers must obtain a SAR from the CCS county program. A SAR is not required for CCS/Medi-Cal beneficiaries. Providers are to refer to this Handbook prior to treating CCS-only, CCS/Healthy Families, CCS/Medi-Cal, and GHPP/Medi-Cal beneficiaries. **Note:** *CCS-only and CCS/Healthy Families beneficiaries residing in Los Angeles, and Sacramento counties will not be issued a BIC.*

### Emergency Treatment

#### CCS-only and CCS/Healthy Families

Beneficiaries: If there is an emergency condition, the provider may treat the beneficiary for the emergency, yet is required to submit the appropriate form (CDHS 4488 or CDHS 4509) to the CCS county program or CCS State Regional Office by the next business day, requesting a SAR.

#### CCS/Medi-Cal and GHPP/Medi-Cal

Beneficiaries: Providers should refer to the Treating Beneficiaries section of this Provider Handbook for procedures for approval and payment for emergency dental services and for obtaining appropriate authorization for services dictated by emergency situations, which preclude timely advance requests for Denti-Cal TAR/Claim forms.

### Other Coverage

A CCS beneficiary may have other dental coverage (i.e., managed care or indemnity dental insurance coverage). Beneficiaries must apply their other coverage benefits prior to utilizing CCS benefits. Other coverage will be considered as the primary carrier, and CCS will be considered as the secondary carrier and payer of last resort.

### Providers with an Existing CCS Authorization Issued Prior to July 1, 2004

All existing CCS authorizations issued prior to July 1, 2004 will be accepted through the expiration date of the current authorization or the beneficiary's eligibility period, with the exception of orthodontics. Orthodontic authorizations will be valid only for the same treating provider for the duration of the current phase of orthodontics. Providers are to continue submitting claims on the CMS 1500 claim form with a dental claim form attached for payments for CCS-only and CCS/Healthy Families beneficiaries. For CCS/Medi-Cal children, the Denti-Cal claim is to be submitted to the CCS county program or CCS State Regional Office where it will be CCS stamped, dated, signed, and forwarded to Denti-Cal for payment.

When the CCS authorization for non-orthodontic services expires, additional treatment is required, the beneficiary

changes treating providers, there is a change in a treatment plan, and/or a new service is requested by a specialty provider, a new request must be submitted on a CCS Dental and Orthodontic Client SAR (CDHS 4516).

Note: All new treatment requests will adhere to the July 1, 2004 new submission requirements.

### **CCS-only and CCS/Healthy Families Service Code Groupings (SCG)**

An approved SAR will list the SCGs and/or the individual procedure code(s) based on the provider's requested treatment plan and the beneficiary's CCS-eligible medical condition. These 18 SCGs are grouped by treatment plans and procedure codes to assist the CCS county program or CCS State Regional Office in authorizing services based on the beneficiary's CCS-eligible medical condition. Providers are to request a SAR for one or more of the SCGs when requesting an authorization from the CCS county program. If the procedure code is not listed in the SCG(s), the provider may request authorization for an individual procedure code from the Denti-Cal Provider Handbook.

#### **SCG 01 - Preventive Dental Services**

D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1110, D1120, D1201, D1203, D1351

#### **SCG 02 - Orthodontic Services for Medically Handicapping Malocclusion**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

#### **SCG 03 - Primary Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

#### **SCG 04 - Mixed Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0340, D0350, D0470, D8080, D8670, D8680

#### **SCG 05 - Permanent Dentition for Cleft Palate and/or Cleft Lip Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8670, D8680

#### **SCG 06 - Primary Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

#### **SCG 07 - Mixed Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

#### **SCG 08 - Permanent Dentition for Facial Growth Management Orthodontic Services**

D0140, D0210, D0330, D0340, D0350, D0470, D8080, D8660, D8670, D8680

#### **SCG 09 - Oral Surgery Services**

D1510, D1515, D1520, D1525, D5211, D5212, D7111, D7140, D7210, D7220, D7230, D7240, D7250, D9220, D9221, D9230, D9241, D9242, D9248, D9610

#### **SCG 10 - Periodontic Services**

D4210, D4211, D4260, D4261, D4341, D4342, D9110, D9220, D9221, D9230, D9241, D9242, D9248

#### **SCG 11 - Endodontic Services**

D3310, D3320, D3330, D3346, D3347, D3348, D3351, D3352, D3353, D3410, D3421, D3425, D3426, D9220, D9221, D9230, D9241, D9242, D9248

#### **SCG 12 - Restorative Services**

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3230, D3240, D9220, D9221, D9230, D9241, D9242, D9248

#### **SCG 13 - Laboratory Crown Services**

D2710, D2721, D2740, D2751, D2781, D2783, D2791, D9220, D9221, D9230, D9241, D9242, D9248

#### **SCG 14 - Fixed Prosthetic Services**

D6211, D6241, D6245, D6251, D6721, D6740, D6751, D6781, D6783, D6791, D9220, D9221, D9230, D9241, D9242, D9248

#### **SCG 15 - Prosthetic Services for Complete Dentures**

D5110, D5120, D5130, D5140, D5860

#### **SCG 16 - Prosthetic Services for Cast Partial Dentures**

D5213, D5214

#### **SCG 17 - Prosthetic Services for Resin Partial Denture**

D5211, D5212

#### **SCG 18 - Dental Services under General Anesthesia**

D0120, D0150, D0210, D0220, D0230, D0272, D0274, D0330, D1120, D1201, D1203, D1351, D1510, D1515, D1520, D1525, D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2390, D2391, D2392, D2393, D2394, D2930, D2931, D2932, D2933, D2951, D3220, D3230, D3240, D3310, D3320, D3330, D3346, D3347, D3348, D3410, D3421, D3425, D3426, D4210, D4211, D4260, D4261, D4341, D4342, D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D9110, D9220, D9221, D9241, D9242, D9420

### **CCS-only and CCS/Healthy Families Benefits**

The CCS program has the same scope of benefits as the Denti-Cal program with a few exceptions: CCS-only and CCS/Healthy Families have additional benefits and modifications based on frequency and age limitations. The table below lists the additional benefits. Note: The reimbursement rates are the same as those on the Denti-Cal SMA.

<b>CDT-4 Procedure Code</b>	<b>Description of Service</b>	<b>Additional Benefits for CCS-only and CCS/ Healthy Families Benefits</b>
D0210	Intraoral - complete series (including bitewings)	Allowed for final records (or procedure code D0330) for orthodontic treatment
D0330	Panoramic film	One additional benefit for final records (or procedure code D0210) for orthodontic treatment
D0340	Cephalometric film	Allowed for final records for orthodontic treatment
D0350	Oral/facial images (includes intra and extraoral images)	A benefit for final records for orthodontic treatment
D0470	Diagnostic casts	One additional benefit for final records
D1120	Prophylaxis - child	A benefit 4 times per year for prophylaxis or prophylaxis/fluoride
D1201	Topical application of fluoride (including prophylaxis) - child	A benefit 4 times per year for prophylaxis or prophylaxis/fluoride
D1203	Topical application of fluoride (prophylaxis not included) -child	A benefit 4 times per year
D1351	Sealant - per tooth	A benefit: First deciduous molars (B, I, L, and S)
D1351	Sealant - per tooth	A benefit: Second deciduous molars (A, J, K, and T)
D1351	Sealant - per tooth	A benefit: First bicuspid (5, 12, 21 and 28)
D1351	Sealant - per tooth	A benefit: Second Bicuspid (4, 13, 20, and 29)

CDT-4 Procedure Code	Description of Service	Additional Benefits for CCS-only and CCS/ Healthy Families Benefits
D1510	Space maintainer-fixed - unilateral	A benefit to hold space for missing permanent posterior tooth.
D1515	Space maintainer-fixed - bilateral	A benefit to hold space for missing permanent posterior tooth.
D1520	Space maintainer-removable - unilateral	A benefit to hold space for missing permanent posterior tooth.
D1525	Space maintainer-removable - bilateral	A benefit to hold space for missing permanent posterior tooth.
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	No age restrictions
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	No age restrictions
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	No age restrictions
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	No age restrictions
D5110	Complete denture - maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth
D5120	Complete denture - mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5130	Immediate denture - maxillary	A benefit once every year up to age 21 with appropriate documentation due to growth



CDT-4 Procedure Code	Description of Service	Additional Benefits for CCS-only and CCS/ Healthy Families Benefits
D5140	Immediate denture - mandibular	A benefit once every year up to age 21 with appropriate documentation due to growth
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3 <sup>rd</sup> molars.
D5212	Mandibular partial denture - resin base (including any conventional clasps, rest and teeth)	A benefit once every year up to age 21. May replace any missing tooth/teeth except 3 <sup>rd</sup> molars.
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	A benefit for age 16-21. Does not need to oppose a full denture.
D5860	Overdenture - complete, by report	A benefit once every year up to age 21 with appropriate documentation due to growth

### **Contact Listings for Denti-Cal, Medi-Cal Eligibility, GHPP, and CCS**

**Denti-Cal Program** - Providers are to contact the Denti-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and CCS/Healthy Families questions related to payments of claims and/or authorizations of TARs.

Provider Toll-Free Line	(800) 423-0507
Beneficiary Toll-Free Line	(800) 322-6384
Electronic Data Interchange (EDI) Support	(916) 853-7373
Ordering Denti-Cal Forms	Fax (877) 401-7534

**Medi-Cal Program** - Providers are to contact the Medi-Cal Program for CCS/Medi-Cal, GHPP/Medi-Cal, CCS-only, and CCS/Healthy Families eligibility, POS, or Internet questions.

Automated Eligibility Verification System (AEVS)	(800) 456-2387
Eligibility Message Help Desk, POS, and/or Internet Help Desk	(800) 541-5555
Internet Eligibility Web Site	<a href="http://www.medi-cal.ca.gov/">http://www.medi-cal.ca.gov/</a>

#### **CCS Offices**

<http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx>

**GHPP State Office** - Providers are to contact this State office for GHPP-only related questions.

Genetically Handicapped Persons Program MS 8200 PO Box 997413 Sacramento, CA 95899	(916) 327-0470 or (800) 639-0597 Fax (916) 327-1112
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### **CCS-only and CCS/Healthy Families County Programs and CCS State Regional Offices**

Providers are to utilize the following guidelines when selecting the correct CCS county program or CCS State Regional Office:

- ◆ For questions on eligibility, SAR authorizations, and submitting claims in Independent counties, please contact the CCS Independent county office.
- ◆ For questions on eligibility in Dependent counties, please contact the CCS Dependent county office or the appropriate CCS State Regional Office.
- ◆ For questions on prior authorization or submitting claims in Independent counties, contact the appropriate CCS State Regional Office.

## **Orthodontic Services Program**

Denti-Cal Program benefits include medically necessary orthodontic services. Orthodontic services available under this program are limited to only those that meet the general policies and requirements, set forth in Title 22, Sections 51003(e), 51307 and 51506.2. These benefits are available to eligible individuals who are under 21 years of age. Regulations governing the provision of these program benefits are listed in the Manual of Criteria section of this Handbook.

Qualified orthodontists may submit claims for reimbursement of orthodontic services provided to eligible Medi-Cal beneficiaries. Title 22, Section 51223(c) defines a "qualified orthodontist" as a dentist who "confines his practice to the specialty of orthodontics" and who either "has successfully completed a course of advanced study in orthodontics of two years or more in programs recognized by the Council on Dental Education of the American Dental Association" or "has completed advanced training in orthodontics prior to July 1, 1969 and is a member of or eligible for membership in the American Association of Orthodontists."

Denti-Cal has created a manual for orthodontists who are certified to participate in the Orthodontic Services Program. This manual contains the policies, guidelines and procedures outlined in this section, as well as additional information to help orthodontists provide services under this specialized Denti-Cal program. If you are a certified orthodontist and would like a copy of this manual, send your request to:

Denti-Cal  
Attn: Publications Dept.  
PO Box 15609  
Sacramento, CA 95852-0609

Following are the Orthodontic Services Program instructions, including enrollment and certification procedures, submission requirements, billing instructions and processing tips.

## **Enrollment and Orthodontic Certification**

1. You must be an enrolled Denti-Cal provider to qualify for participation in this program. An orthodontist who wishes to submit claims for services provided to eligible Denti-Cal beneficiaries must first complete an Orthodontia Provider Certification form. For an enrollment application and information, please call Denti-Cal at (800) 423-0507.
2. Complete the Orthodontia Provider Certification form and return it promptly to Denti-Cal. Denti-Cal will enter an appropriate code on your automated provider records to establish and identify you as a provider under the Orthodontic Services Program.
3. Denti-Cal will notify you in writing when the certification has been approved.
4. Denti-Cal will furnish an initial supply of HLD score sheets upon certification approval. Additional HLD score sheets (DC016) may be obtained through the Denti-Cal forms supplier by checking the appropriate box on the Denti-Cal Forms Reorder Request.
5. Every certified orthodontist must be listed with Denti-Cal as a rendering provider in each service office in which he or she treats patients. It is the responsibility of the certified orthodontist to make sure that he/she is authorized by Denti-Cal to provide treatment in a particular service office.

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## **Justification of Need for Prosthesis**

The Justification of Need for Prosthesis Form is designed to provide complete and detailed information necessary for screening and processing prosthetic cases. This form is required when submitting a Treatment Authorization Request (TAR) for full upper and lower dentures, partial dentures and stayplates (Procedures D5110, D5120, D5130, D5140, D5211, D5212, D5213, D5214, and D5860). Providers should document specific information describing the condition of the beneficiary's oral condition and any existing prosthesis. Documentation must include:

- ◆ missing teeth;
- ◆ teeth to be extracted;
- ◆ teeth being replaced by the requested prosthesis (excluding third molars);
- ◆ teeth being clasped (applies to cast framework partial or resin base partial).

It is the provider's responsibility to document conditions that Denti-Cal will need for determining the beneficiary's ability to adapt to a prosthesis. If a provider fails to submit a Justification of Need for Prosthesis Form or provides incomplete documentation on the form, Denti-Cal will issue a RTD for the necessary information, which will delay processing of the request. If the Justification of Need for Prosthesis is incomplete or incorrect, it will be denied.

The Justification of Need for Prosthesis Form (DC054) is provided free of charge and may be ordered from the Denti-Cal forms supplier. Instructions for completing the form are as follows:

## JUSTIFICATION OF NEED FOR PROSTHESIS

### *Complete Dentures, Resin Base Partial Dentures, Cast Metal Framework Partial Dentures*

This form is to be completed by the dentist providing treatment. Both arches must be evaluated and addressed. Chart missing teeth and teeth to be extracted. Complete each section of the form. Attach this form to the submitted TAR.

① PATIENT: \_\_\_\_\_ ② DATE: \_\_\_\_\_

#### ADDRESS BOTH ARCHES -- COMPLETE EACH APPROPRIATE ITEM (TYPE OR PRINT CLEARLY)

	MAXILLARY ARCH	MANDIBULAR ARCH																																																																																																																	
③	Appliance Requested: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD Existing Appliance: <input type="checkbox"/> FUD <input type="checkbox"/> Cast Metal PUD <input type="checkbox"/> Resin base PUD <input type="checkbox"/> Never had a maxillary prosthetic appliance Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No      Age of Appliance: _____ Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No    **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report. If lost in facility or hospital, explain circumstances: _____	Appliance Requested: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD Existing Appliance: <input type="checkbox"/> FLD <input type="checkbox"/> Cast Metal PLD <input type="checkbox"/> Resin base PLD <input type="checkbox"/> Never had a mandibular prosthetic appliance Wears appliance? <input type="checkbox"/> Yes <input type="checkbox"/> No      Age of Appliance: _____ Catastrophic Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No    **Catastrophic loss (fire, earthquake, theft, etc.) requires attachment of Official Public Service Agency Report. If lost in facility or hospital, explain circumstances: _____																																																																																																																	
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REQUIRED FIELD FOR PARTIAL DENTURES (All Types)	
⑥ MAXILLARY ARCH Teeth Being Replaced: _____ Teeth Being Clapsed: _____	MANDIBULAR ARCH Teeth Being Replaced: _____ Teeth Being Clapsed: _____

If treatment involves retaining teeth in the arch(es), indicate treatment plan for remaining teeth (Root canals, periodontal treatment, restorative, crowns, etc.): \_\_\_\_\_

⑦ Does the patient want requested services? ☐ No ☐ Yes

⑧ Does health condition of the patient limit dental adaptability? ☐ No ☐ Yes    Explain: \_\_\_\_\_

⑨ ADDITIONAL COMMENTS: \_\_\_\_\_

⑩ CONVALESCENT CARE: Comments about patient's condition as stated by Charge Nurse / Social Services / Caregiver: \_\_\_\_\_

⑪ Provider Signature \_\_\_\_\_ License # \_\_\_\_\_

**How to Complete the Justification of Need  
for Prosthesis Form**

1. **PATIENT NAME:** Enter the patient's name exactly as it appears on the Medi-Cal Benefits Identification Card.
2. **DATE:** Enter the date the patient was evaluated.
3. **APPLIANCE TYPE:** Enter the type of prosthetic appliance the patient has or had. Indicate whether the appliance is present, the age of the existing appliance and whether the patient wears the appliance. If the TAR is for the initial placement of a prosthetic appliance, check the "initial placement" box and use the comments field to indicate the type of appliance being requested.  
  
If the appliance has been lost, stolen or discarded, document the date of the incident and the circumstances of the loss. The section in the lower part of the Justification of Need for Prosthesis Form has additional space for documenting details of the loss.
4. **EVALUATION OF EXISTING DENTURES:** Document the condition of the existing denture base, denture teeth, retention, opposing dentition (if applicable), vertical relation and centric occlusion. If the existing appliance is a cast metal framework partial denture, document the condition of the framework.  
  
Evaluate the condition of the patient's soft tissue and hard tissue (bone). If soft tissue or hard tissue is checked "inadequate," indicate the procedure that will be necessary to correct the inadequacy prior to the construction of an appliance, i.e., tissue conditioning, tuberosity reduction, excision of hyperplastic tissue, removal of tori, etc.
5. **MISSING TEETH:** Use an "X" to block out missing teeth on the numerical diagram of the dentition. If teeth are to be extracted, circle the appropriate tooth numbers. If the arch is edentulous, check the corresponding box.
6. **CAST FRAMEWORK PARTIAL OR RESIN BASE PARTIAL:** Indicate the teeth being replaced by the requested appliance and the teeth being clasped.
7. **DOES THE PATIENT WANT REQUESTED SERVICES?** After discussing the proposed treatment plan with the patient, indicate whether the patient wants the proposed services.
8. **DOES HEALTH CONDITION OF PATIENT LIMIT ADAPTABILITY?** Indicate any conditions that might limit the adaptability of the patient to wear a prosthetic appliance. Document if the condition is temporary or permanent.
9. **ADDITIONAL COMMENTS:** Use this section as necessary for additional comments or documentation specific to the requested treatment.
10. **CONVALESCENT CARE:** If the patient resides in a convalescent facility, use this field to document facility staff comments regarding the resident's ability to benefit by or adapt to the requested treatment.
11. **SIGNATURE AND LICENSE NUMBER:** The dentist completing the form should sign the form and enter his/her dental license number.

# Sample Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet

## HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORE SHEET

(You will need this score sheet and a Boley Gauge or a disposable ruler)

Provider

Patient

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Number: \_\_\_\_\_

Date: \_\_\_\_\_

- Position the patient's teeth in centric occlusion.
- Record all measurements in the order given and round off to the nearest millimeter (mm).
- ENTER SCORE '0' IF CONDITION IS ABSENT.

### CONDITIONS #1 – #6A ARE AUTOMATIC QUALIFYING CONDITIONS

HLD Score

1. Cleft palate deformity (See scoring instructions for types of acceptable documentation).  
Indicate an 'X' if present and score no further. \_\_\_\_\_
2. Cranio-facial anomaly (Attach description of condition from a credentialed specialist).  
Indicate an 'X' if present and score no further. \_\_\_\_\_
3. Deep impinging overbite **WHEN LOWER INCISORS ARE DESTROYING THE SOFT TISSUE OF THE PALATE.  
TISSUE LACERATION AND/OR CLINICAL ATTACHMENT LOSS MUST BE PRESENT.**  
Indicate an 'X' if present and score no further. \_\_\_\_\_
4. Crossbite of individual anterior teeth **WHEN CLINICAL ATTACHMENT LOSS AND RECESSION OF THE  
GINGIVAL MARGIN ARE PRESENT.**  
Indicate an 'X' if present and score no further. \_\_\_\_\_
5. Severe traumatic deviation. (Attach description of condition. For example: loss of a premaxilla segment by burns  
or by accident, the result of osteomyelitis, or other gross pathology.)  
Indicate an 'X' if present and score no further. \_\_\_\_\_
- 6A. Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.  
Indicate an 'X' if present and score no further. \_\_\_\_\_

### THE REMAINING CONDITIONS MUST SCORE 26 OR MORE TO QUALIFY

- 6B. Overjet equal to or less than 9 mm . . . . . \_\_\_\_\_
7. Overbite in mm . . . . . \_\_\_\_\_
8. Mandibular protrusion (reverse overjet) equal to or less than 3.5 mm . . . . . \_\_\_\_\_ x 5 = \_\_\_\_\_
9. Open bite in mm . . . . . \_\_\_\_\_ x 4 = \_\_\_\_\_

**IF BOTH ANTERIOR CROWDING AND ECTOPIC ERUPTION ARE PRESENT IN THE ANTERIOR PORTION OF THE SAME ARCH,  
SCORE ONLY THE MOST SEVERE CONDITION. DO NOT COUNT BOTH CONDITIONS.**

10. Ectopic eruption (Identify by tooth number, and count each tooth, excluding third molars) \_\_\_\_\_ x 3 = \_\_\_\_\_  
tooth numbers total
11. Anterior crowding (Score one for MAXILLA, and/or one for MANDIBLE) \_\_\_\_\_ x 5 = \_\_\_\_\_  
maxilla mandible total
12. Labio-Lingual spread in mm . . . . . \_\_\_\_\_
13. Posterior unilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar.  
No score for bi-lateral posterior crossbite). . . . . Score 4 \_\_\_\_\_

TOTAL SCORE: \_\_\_\_\_

IF A PATIENT DOES NOT SCORE 26 OR ABOVE NOR MEETS ONE OF THE SIX AUTOMATIC QUALIFYING CONDITIONS, HE/SHE MAY BE ELIGIBLE UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT – SUPPLEMENTAL SERVICES (EPSDT-SS) EXCEPTION IF MEDICAL NECESSITY IS DOCUMENTED.

☐ **EPSDT-SS EXCEPTION:** (Indicate with an 'X' and attach medical evidence and appropriate documentation for each of the following eight areas on a separate piece of paper IN ADDITION TO COMPLETING THE HLD SCORE SHEET ABOVE.)

- a) Principal diagnosis and significant associated diagnosis; and
- b) Prognosis; and
- c) Date of onset of the illness or condition and etiology if known; and
- d) Clinical significance or functional impairment caused by the illness or condition; and
- e) Specific types of services to be rendered by each discipline associated with the total treatment plan; and
- f) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals; and
- g) The extent to which health care services has been previously provided to address the illness or condition, and results demonstrated by prior care; and
- h) Any other documentation which may assist the Department in making the required determinations.

DO NOT WRITE IN THIS AREA.

DC016 (R 04/07)



## How to Complete the HLD Index Scoresheet

### HANDICAPPING LABIO-LINGUAL DEVIATION (HLD) INDEX CALIFORNIA MODIFICATION SCORING INSTRUCTIONS

The intent of the HLD Index is to measure the presence or absence, and the degree, of the handicap caused by the components of the Index, and not to diagnose 'malocclusion.' All measurements are made with a Boley Gauge (or a disposable ruler) scaled in millimeters. Absence of any conditions must be recorded by entering '0.' (Refer to the attached scoresheet).

The following information should help clarify the categories on the HLD Index:

1. **Cleft Palate Deformity:** Acceptable documentation must include at least one of the following: 1) diagnostic casts; 2) intraoral photograph of the palate; 3) written consultation report by a qualified specialist or Craniofacial Panel. Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
2. **Cranio-facial Anomaly:** (Attach description of condition from a credentialed specialist) Indicate an 'X' on the score sheet. Do not score any further if present. (This condition is automatically considered to qualify for orthodontic services.)
3. **Deep Impinging Overbite:** Indicate an 'X' on the score sheet when lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
4. **Crossbite of Individual Anterior Teeth:** Indicate an 'X' on the score sheet when clinical attachment loss and recession of the gingival margin are present. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
5. **Severe Traumatic Deviation:** Traumatic deviations are, for example, loss of a premaxilla segment by burns or by accident; the result of osteomyelitis; or other gross pathology. Indicate an 'X' on the score sheet and attach documentation and description of condition. Do not score any further if present. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
- 6A **Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm:** Overjet is recorded with the patient's teeth in centric occlusion and is measured from the labial of the lower incisors to the labial of the corresponding upper central incisors. This measurement should record the greatest distance between any one upper central incisor and it's corresponding lower central or lateral incisor. If the overjet is greater than 9mm or mandibular protrusion (reverse overjet) is greater than 3.5mm, indicate an 'X' and score no further. (This condition is automatically considered to be a handicapping malocclusion without further scoring.)
- 6B **Overjet equal to or less than 9mm:** Overjet is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter and entered on the score sheet.
7. **Overbite in Millimeters:** A pencil mark on the tooth indicating the extent of overbite facilitates this measurement. It is measured by rounding off to the nearest millimeter and entered on the score sheet. (Reverse overbite may exist in certain conditions and should be measured and recorded.)
8. **Mandibular Protrusion (reverse overjet) equal to or less than 3.5mm:** Mandibular protrusion (reverse overjet) is recorded as in condition #6A above. The measurement is rounded off to the nearest millimeter. Enter on the score sheet and multiply by five (5).
9. **Open Bite in Millimeters:** This condition is defined as the absence of occlusal contact in the anterior region. It is measured from incisal edge of a maxillary central incisor to incisal edge of a corresponding mandibular incisor, in millimeters. The measurement is entered on the score sheet and multiplied by four (4). In cases of pronounced protrusion associated with open bite, measurement of the open bite is not always possible. In those cases, a close approximation can usually be estimated.
10. **Ectopic Eruption:** Count each tooth, excluding third molars. Each qualifying tooth must be more the 50% blocked out of the arch. Count only one tooth when there are mutually blocked out teeth. Enter the number of qualifying teeth on the score sheet and multiply by three (3). If anterior crowding (condition #11) also exists in the same arch, score the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
11. **Anterior Crowding:** Arch length insufficiency must exceed 3.5mm. Mild rotations that may react favorably to stripping or mild expansion procedures are not to be scored as crowded. Score one (1) for a crowded maxillary arch and/or one (1) for a crowded mandibular arch. Enter total on the score sheet and multiply by five (5). If ectopic eruption (condition #10) exists in the anterior region of the same arch, count the condition that scores the most points. **DO NOT COUNT BOTH CONDITIONS.** However, posterior ectopic teeth can still be counted separately from anterior crowding when they occur in the same arch.
12. **Labio-Lingual Spread:** A Boley Gauge (or a disposable ruler) is used to determine the extent of deviation from a normal arch. Where there is only a protruded or lingually displaced anterior tooth, the measurement should be made from the incisal edge of that tooth to the normal arch line. Otherwise, the total distance between the most protruded anterior tooth and the most lingually displaced adjacent anterior tooth is measured. In the event that multiple anterior crowding of teeth is observed, all deviations from the normal arch should be measured for labio-lingual spread, but only the most severe individual measurement should be entered on the score sheet.
13. **Posterior Unilateral Crossbite:** This condition involves two or more adjacent teeth, one of which must be a molar. The crossbite must be one in which the maxillary posterior teeth involved may either be both palatal or both completely buccal in relation to the mandibular posterior teeth. The presence of posterior unilateral crossbite is indicated by a score of four (4) on the score sheet. **NO SCORE FOR BI-LATERAL CROSSBITE.**

## **Initial Orthodontic Evaluation, Diagnostic Casts and Orthodontic Treatment Plan**

### **Initial Orthodontic Evaluation**

1. Prior to initiating the TAR for orthodontic services, orthodontists must first complete the initial orthodontic examination (D0140) which includes completion of the Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet that documents the medical necessity for orthodontic services. An example of the HLD Score Sheet and instructions on how to complete the form are shown in the Manual of Criteria or the Forms sections in this Handbook.

Note: When completing the HLD Score Sheet, please remember that it must meet all documentation requirements to be considered complete. For example, in instances of severe traumatic deviation, please document the nature of the traumatic deviation.

2. Submit a claim for payment for Procedure D0140, Initial Orthodontic Exam.

### **Diagnostic Casts**

1. If the patient meets the qualifying factors on the HLD Score Sheet, Diagnostic Casts (Procedure D0470) may be taken on your patient. Prior authorization is not required for the diagnostic casts; however, orthodontic treatment must be approved to receive payment for the diagnostic casts.
2. The diagnostic casts must be submitted to Denti-Cal for review when payment is requested.

Note: Diagnostic casts should be a second pour and clearly labeled with the patient's name, Benefits Identification Number (BIC), and the provider's name. If the diagnostic casts are received without patient identification, they will be destroyed.

Careful packaging of diagnostic casts and bite registration will help ensure they arrive at Denti-Cal in good condition.

Many are received broken and damaged due to poor packaging, which causes processing delays and unnecessary duplication of diagnostic casts. Use a box that has sufficient packaging material (such as styrofoam "peanuts," shredded newspaper, "bubble wrap," etc.) so that diagnostic casts will not be jarred or bumped during shipping. Also, be sure to place some packaging material between the upper and lower arches to prevent rubbing and possible chipping and breakage of the teeth.

Please do not mail the diagnostic casts in the same envelope or mailing container as the claim for the diagnostic casts and the TAR for orthodontic treatment. The diagnostic casts should be packaged separately for mailing to Denti-Cal at the same time as the claim and TAR.

### **Orthodontic Treatment Plan**

1. Submit for prior authorization a complete orthodontic treatment plan. The following are required for consideration:

#### **A. TAR:**

- ◆ Comprehensive orthodontic treatment of the adolescent dentition (D8080)
- ◆ Periodic orthodontic treatment visit(s) (D8670)  
  
Note: Document the case type and dentition phase in the comment section (box 34).
- ◆ Orthodontic retention (D8680)
- ◆ Any necessary radiographs such as complete series (D0210) or Panoramic film (D0330), and cephalometric films (D0340) should also be requested on the TAR.

#### **B. HLD Score Sheet**

#### **C. Diagnostic Casts**

Note: Pre-orthodontic treatment visits (D8660) may be requested prior to starting orthodontic treatment for a patient with a qualifying craniofacial anomaly. Submit a separate TAR, indicate the quantity and attach all appropriate

documentation. Once procedure D8660 has been completed or is no longer required, submit a new TAR requesting the complete orthodontic treatment plan.

2. The Denti-Cal orthodontic consultant will evaluate the HLD Score Sheet, and the diagnostic casts or documentation (as applicable for cleft palate and craniofacial anomaly cases) to determine if the case qualifies.

### **Clarification of Case Types**

#### **Malocclusion Cases**

Malocclusion cases may only be started with permanent dentition, or at 13 years of age. If a malocclusion case requires further treatment beyond 24 visits, a maximum of 12 additional visits may be authorized upon review of progress photographs and documentation.

#### **Cleft Palate Cases**

Cleft palate cases may be treated from birth in the primary dentition phase, in the mixed dentition phase, and again in the permanent dentition phase. If the cleft palate cannot be demonstrated on the diagnostic casts, documentation from a credentialed specialist must be attached.

If the primary dentition case requires further treatment beyond 10 visits, a maximum of 5 additional visits may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 14 visits, a maximum of 7 additional visits may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 30 visits, a maximum of 15 additional visits may be authorized upon review of progress photographs and documentation.

#### **Craniofacial Anomaly Cases**

Craniofacial anomalies cases may also be treated from birth in the primary dentition phase, again in the mixed dentition, and again in the permanent dentition phase. Documentation from a credentialed specialist

is required for all craniofacial anomaly cases. Submission of the diagnostic casts is optional.

Procedure D8660 - Pre-orthodontic Treatment Visits are a benefit for craniofacial anomaly cases only to monitor the patient's dentition and/or facial growth prior to starting orthodontic treatment. Procedure D8660 is optional and should be submitted separately for prior authorization if they are necessary.

If the primary dentition case requires further treatment beyond 10 visits, a maximum of 5 additional visits may be authorized upon review of progress photographs and documentation.

If the mixed dentition case requires further treatment beyond 14 visits, a maximum of 7 additional visits may be authorized upon review of progress photographs and documentation.

If the permanent dentition case requires further treatment beyond 24 visits, a maximum of 12 additional visits may be authorized upon review of progress photographs and documentation.

### Helpful Hints

If a patient transfers from one certified Denti-Cal orthodontist to another certified Denti-Cal orthodontist, prior authorization is necessary before continuing treatment. Diagnostic casts are not required if the treatment has already been approved by Denti-Cal.

Transfer of a case in progress by another carrier requires prior authorization. Original diagnostic casts, along with new casts or progress photographs and any other documentation must be submitted for evaluation. Only orthodontic cases that meet the program criteria will be authorized for the remaining treatment determined by the Denti-Cal orthodontic consultant.

When additional orthodontic services are required or there is a change in the authorized treatment plan, submit a new TAR with documentation and any NOAs that have not been used.

The TAR submitted for Procedures D8670 and D8660 must list the total quantity or frequency (number of treatments necessary to complete the treatment) in the "Quantity" field, column #30 and the total fee (fee for the procedure times the number of treatments) in the "Fee" field, column #32. The example below shows the correct way to list these procedures to ensure accurate calculation of the Notice of Authorization.

EXAMINATION AND TREATMENT							
26. TODAY'S APPROVAL	27. SURFACES	28. DESCRIPTION OF SERVICE (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	29. DATE SERVICE PERFORMED	30. QUANTITY	31. PROCEDURE NUMBER	32. FEE	33. PENDING PROVIDER NO.
		1 Comprehensive Ortho Tx.			D8080	975.00	
		2 Periodic Ortho Tx. Visits		24	D8670	1000.00	
U		3 Retention		01	D8680	375.00	
L		4 Retention		01	D8680	375.00	
		5 Full Mouth Series			D0210	80.00	
		6					
		7					

Frequency (# of Treatments)

Total Fee  
(# of treatments x UCR)

### Treatment Plan Authorization and Payment Submission Procedures

- When the TAR for orthodontic services is approved by Denti-Cal, a series of Notices of Authorization will be issued confirming authorization. Notices of Authorization will be sent at the beginning of the authorization date and every three months thereafter throughout the treatment plan authorization period. These Notices of Authorization should be used for monthly billing purposes.
- Each month when services are provided, submit one NOA to Denti-Cal for payment.

NOAs for payment will be processed in accordance with general Denti-Cal billing policies and criteria requirements for Orthodontic Services. Please remember

that authorization does not guarantee payment. Payment is subject to patient eligibility.

Please note: If payment of a NOA is denied, submit a CIF for reevaluation. Do not resubmit for the same date of service using a new NOA.

- Under the Denti-Cal orthodontic program, confirmation of continued treatment is required at the end of each 12 months of authorized treatment. You will receive an RTD requesting your signature to confirm continued treatment for the subsequent 12 months or remaining treatment. You must indicate your intent to continue treatment by signing the RTD.

## **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services**

### **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services**

EPSDT services are the current Denti-Cal Program's scope of benefits for beneficiaries under the age of 21. EPSDT was further defined by federal law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) and includes dental services. In addition, Section 1905(4)(5) of the Social Security Act requires that a medically necessary health care service listed in Section 1905(a) be provided to an EPSDT beneficiary even if the service is not under a state's Medicaid plan to the rest of the Medicaid population.

The Department established regulations, effective on April 4, 1994, and amended effective April 27, 1995, to clarify the Department's implementation of the EPSDT program within Medi-Cal. The applicable regulations, contained within Title 22 of the California Code of Regulations, are Sections 51184, 51242, 51304, 51340, 51340.1 and 51532.

### **EPSDT: Frequently Asked Questions**

#### **What is EPSDT?**

The early and periodic screening, diagnosis, and treatment (EPSDT) program is a special process within Denti-Cal specifically for children. Under federal law, EPSDT services are provided to any Medicaid beneficiary under age 21. For the Denti-Cal Program, this means medically necessary dental services provided for any Denti-Cal beneficiary who has not yet reached his or her 21st birthday are EPSDT services.

#### **What Kind of Dental Services are Classified as EPSDT?**

Whenever a Denti-Cal provider completes an oral examination on a child, an EPSDT screening service (and diagnostic service) has occurred. Any subsequent dental treatment resulting from that examination is considered an EPSDT dental service *if* the dental procedure is published in the Denti-Cal Manual of Criteria.

## **Early and Periodic Screening, Diagnostic and Treatment Supplemental Services (EPSDT-SS)**

EPSDT beneficiaries may require dental services that are not part of the current Denti-Cal program of benefits. Conversely, the dental service may be part of the Denti-Cal Program scope of benefits for adults but not for children or the dental provider may want to provide the service at a frequency or periodicity greater than currently allowed by the Denti-Cal Program. In these cases, such dental services are called EPSDT Supplemental Services (EPSDT-SS).

### **What is an EPSDT Supplemental Service?**

Medi-Cal enrolled children may need dental services that are not part of the scope of benefits found within the Manual of Criteria. Denti-Cal covers these services, too. In California, these services are called EPSDT Supplemental Services or "EPSDT-SS."

Example 1: John S. has a craniofacial anomaly with multiple edentulous areas. The edentulous areas cannot be adequately restored using conventional prosthetics - an implant-retained fixed prosthesis may be authorized as an EPSDT Supplemental Service.

EPSDT-SS also covers situations when the dental service being requested may be listed in the Manual of Criteria, but the child does not meet the published criteria.

Example 2: Cindy T. (age 10) suffers from aggressive periodontitis and requires periodontal scaling and root planing. The Manual of Criteria, however, states this procedure is not a benefit for patients under 13 years of age. The medically necessary periodontal procedures may be authorized as EPSDT Supplemental Services.

Example 3: Alicia M. (age 12) has fractured an anterior tooth in an accident. Although only three surfaces were involved in the traumatic destruction, the extent is such that a bonded restoration will not be retentive. With adequate supplemental documentation (in this case, intraoral photographs of the fractured tooth) and narrative explanation by the dentist, a prefabricated or laboratory-processed crown may be authorized as an EPSDT Supplemental Service.

Example 4: Andre W. does not qualify for orthodontic services per the handicapping malocclusion criteria (he scores below 26 points on the HLD Index Score Sheet or does not have one of the five automatic qualifying conditions). However, a speech pathologist has determined that his malocclusion is a prime etiologic factor in his speech pathosis - resolution cannot be achieved unless his malocclusion is corrected. In this case, orthodontics may be authorized as an EPSDT Supplemental Service.

### **When Would I Request an EPSDT Supplemental Service for My Child Patients?**

You would request prior authorization for an EPSDT Supplemental Service under any one of the following conditions:

- 1) To perform a medically necessary dental procedure that is not listed in the current Manual of Criteria.
- 2) To perform a medically necessary dental procedure that is listed in the current Manual of Criteria when the child does not meet the published criteria.
- 3) The child needs a dental service more frequently than is currently allowed under Program criteria.

### **How Do I Request an EPSDT Supplemental Service?**

All EPSDT Supplemental Services must be prior authorized and you **MUST** print "EPSDT Supplemental Services Request" in Field 34 of the TAR/Claim form. If the requested dental service is not listed within the Manual of Criteria, use the appropriate unspecified procedure code and fully describe the service. Do not limit your comments to Field 34 of the TAR/Claim form - attach all documents that are needed to describe the requested services.

### **What Kind of Clinical Information Does the Program Need to Determine the Medical Necessity?**

At a minimum, you should address the following:

- ◆ Diagnosis of the dental condition

- ◆ Any overall health issues and medical conditions
- ◆ Prognosis with and without the requested treatment
- ◆ Clinical rationale for why a covered benefit or lower-cost service will not suffice (you are encouraged to include copies of published clinical studies or articles from peer-reviewed, professional dental journals to support your rationale).

Note: Documentation can be narrative, radiographic, photographic, or copies of any relevant documents (including diagnostic imaging).

In some cases, the dental services are necessary to resolve or improve an associated medical condition. For example, a child's speech therapist determines that a diagnosed speech pathosis cannot be resolved without dental treatment. A consultation letter from the speech therapist should be included with the EPSDT Supplemental Services TAR/Claim.

It is virtually impossible to submit too much documentation with your TAR for EPSDT Supplemental Services!

### **Whom Can I Call to Obtain Further Information About the EPSDT and EPSDT-SS Requirements Under Denti-Cal?**

Denti-Cal Telephone Service Center Representatives are available toll-free, (800) 423-0507, to answer all of your questions regarding EPSDT services and EPSDT Supplemental Services.

### **EPSDT-SS Requests for Orthodontic Services**

All EPSDT-SS requests for orthodontic services must include a completed Handicapping Labio-Lingual Deviation (HLD) Index Score Sheet (DC016) in addition to the aforementioned documentation requirements. The review of active orthodontic services also requires the submission of diagnostic casts.

For detailed instructions on how to complete the HLD Index, refer to the Forms section of this Handbook.

**Child Health and Disability  
Prevention (CHDP)/Children's  
Treatment Program (CTP)**

As an expansion of the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, the State has developed the Child Health and Disability Prevention (CHDP) Treatment Mandate, which is a program that provides health assessment screenings to Medi-Cal eligible children from birth to age 19.

The CHDP Mandate states that any county receiving funds for uncompensated care "shall provide, or arrange and pay for, medically necessary follow-up treatment, including necessary follow-up dental services and prescription drugs, for any condition detected as part of a CHDP screening for a child eligible for services under the CHDP program." The legislation allows County Medical Services Program (CMSP) counties to contract back with the Department to administer their CHDP treatment mandate/obligation. The Department of Public Health administers this mandate for these counties under the Children's Treatment Program (CTP).

To qualify for CTP services, beneficiaries must be under 19 years of age; must meet CHDP eligibility requirements; and cannot be covered by private health insurance or Medi-Cal with no share of cost, California Children's Services or any other publicly funded program. The CTP allows eligible beneficiaries to be treated by Medi-Cal providers and uses Medi-Cal procedure codes, rates and scope of benefits.

Claims having a secondary aid code of 8Y or 94, that would otherwise be denied due to lack of Emergency Certification, will be processed *if* accompanied by a CHDP Prevention Assessment (PM 160) form. Aid Code 8Y is now identified as always exempt from the \$1,800 dental cap limitation.

Every eligible child and family is informed of the importance of dental services and is offered assistance in receiving services. It is recommended that a child obtain a referral at age 1 and required to obtain a referral at age 3. Referrals should be made at any age based upon circumstances. Providers who render services to children eligible for

CTP/CHDP will no longer receive a cancelled TAR. Instead, effective immediately, a NOA will automatically be mailed. The following message will now print on the NOA:

Please submit a current PM 160 form with NOA when requesting payment.

Reminder: When submitting a TAR/Claim or a claim for services provided to children eligible for CTP/CHDP *always check "Yes" in Field 16* on the TAR or claim and include proof of Medi-Cal eligibility.

The following is a list of beneficiary counties qualified for CTP services:

County Name	County Code
Alpine	02
Amador	03
Butte	04
Calaveras	05
Colusa	06
Del Norte	08
El Dorado	09
Glenn	11
Humboldt	12
Imperial	13
Inyo	14
Kings	16
Lake	17
Lassen	18
Madera	20
Marin	21
Mariposa	22
Mendocino	23
Modoc	25
Mono	26
Napa	28
Nevada	29
Plumas	32
San Benito	35
Shasta	45
Sierra	46
Siskiyou	47
Solano	48
Sonoma	49
Sutter	51
Tehama	52
Trinity	53
Tuolumne	55
Yuba	58

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## CHDP/CTP Schedule of Maximum Allowances

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
  - a. provider's billed amount
  - b. the maximum allowance set forth in the schedule below
2. Refer to your Denti-Cal Provider Handbook for specific procedure instructions and program limitations.

**Not a Benefit:** Dental or medical health care services not covered by the Medi-Cal program

**Global:** Treatment performed in conjunction with another procedure which is not payable separately

CDT-4 Codes	Procedure Code Description	Maximum \$\$ Allowance
<b>Diagnostic</b>		
D0120	Periodic oral evaluation	\$15.00
D0140	Limited oral evaluation - problem focused	\$35.00
D0150	Comprehensive oral evaluation - new or established patient	\$25.00
D0160	Detailed and extensive oral evaluation - problem focused, by report	\$100.00
D0170	Reevaluation - limited, problem focused (established patient; not post-operative visit)	\$75.00
D0180	Comprehensive periodontal evaluation - new or established patient	Global
D0210	Intraoral - complete series (including bitewings)	\$40.00
D0220	Intraoral - periapical first film	\$10.00
D0230	Intraoral - periapical each additional film	\$3.00
D0240	Intraoral - occlusal film	\$10.00
D0250	Extraoral - first film	\$22.00
D0260	Extraoral - each additional film	\$5.00
D0270	Bitewing - single film	\$5.00
D0272	Bitewings - two films	\$10.00
D0274	Bitewings - four films	\$18.00
D0277	Vertical bitewings - 7 to 8 films	Global
D0290	Posterior - anterior or lateral skull and facial bone survey film	\$35.00
D0310	Sialography	\$100.00
D0320	Temporomandibular joint arthrograph, including injection	\$76.00
D0321	Other temporomandibular joint arthrograph, including injection	Not A Benefit
D0322	Tomographic survey	\$100.00
D0330	Panoramic film	\$25.00
D0340	Cephalometric film	\$50.00
D0350	Oral/Facial images (including intra and extraoral images)	\$6.00
D0415	Bacteriologic studies for determination of pathologic agents	Not A Benefit
D0425	Caries susceptibility tests	Not A Benefit
D0460	Pulp vitality tests	Global
D0470	Diagnostic casts	\$75.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D0472	Accession of tissue, gross examination, preparation and transmission of written report	Not A Benefit
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	Not A Benefit
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	Not A Benefit
D0480	Processing and interpretation of cytologic smears, including the preparation and transmission of written report	Not A Benefit
D0502	Other oral pathology procedures, by report	By Report
D0999	Unspecified diagnostic procedure, by report	\$46.00

#### **Preventive**

D1110	Prophylaxis - adult	\$40.00
D1120	Prophylaxis - child	\$30.00
D1201	Topical application of fluoride (including prophylaxis) - child	\$35.00
D1203	Topical application of fluoride (prophylaxis not included) - child	\$8.00
D1204	Topical application of fluoride (prophylaxis not included) - adult	\$6.00
D1205	Topical application of fluoride (including prophylaxis) - adult	\$40.00
D1310	Nutritional counseling for control of dental disease	Global
D1320	Tobacco counseling for the control and prevention of oral disease	Global
D1330	Oral hygiene instructions	Global
D1351	Sealant - per tooth	\$22.00
D1510	Space maintainer-fixed - unilateral	\$120.00
D1515	Space maintainer-fixed - bilateral	\$200.00
D1520	Space maintainer-removable - unilateral	\$230.00
D1525	Space maintainer-removable - bilateral	\$230.00
D1550	Re-cementation of space maintainer	\$30.00

#### **Restorative**

D2140	Amalgam - one surface, primary or permanent	\$39.00
D2150	Amalgam - two surfaces, primary or permanent	\$48.00
D2160	Amalgam - three surfaces, primary or permanent	\$57.00
D2161	Amalgam - four or more surfaces, primary or permanent	\$60.00
D2330	Resin-based composite - one surface, anterior	\$55.00
D2331	Resin-based composite - two surfaces, anterior	\$60.00
D2332	Resin-based composite - three surfaces, anterior	\$65.00
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$85.00
D2390	Resin-based composite crown, anterior	\$75.00
D2391	Resin-based composite - one surface, posterior	\$39.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D2392	Resin-based composite - two surfaces, posterior	\$48.00
D2393	Resin-based composite - three surfaces, posterior	\$57.00
D2394	Resin-based composite - four or more surfaces, posterior	\$60.00
D2410	Gold foil - one surface	Not A Benefit
D2420	Gold foil - two surfaces	Not A Benefit
D2430	Gold foil - three surfaces	Not A Benefit
D2510	Inlay - metallic - one surface	Not A Benefit
D2520	Inlay - metallic - two surfaces	Not A Benefit
D2530	Inlay - metallic - three surfaces	Not A Benefit
D2542	Onlay - metallic - two surfaces	Not A Benefit
D2543	Onlay - metallic - three surfaces	Not A Benefit
D2544	Onlay - metallic - four or more surfaces	Not A Benefit
D2610	Inlay - porcelain/ceramic - one surface	Not A Benefit
D2620	Inlay - porcelain/ceramic - two surfaces	Not A Benefit
D2630	Inlay - porcelain/ceramic - three or more surfaces	Not A Benefit
D2642	Onlay - porcelain/ceramic - two surfaces	Not A Benefit
D2643	Onlay - porcelain/ceramic - three surfaces	Not A Benefit
D2644	Onlay - porcelain/ceramic - four or more surfaces	Not A Benefit
D2650	Inlay - resin-based composite - one surface	Not A Benefit
D2651	Inlay - resin-based composite - two surfaces	Not A Benefit
D2652	Inlay - resin-based composite - three or more surfaces	Not A Benefit
D2662	Onlay - resin-based composite - two surfaces	Not A Benefit
D2663	Onlay - resin-based composite - three surfaces	Not A Benefit
D2664	Onlay - resin-based composite - four or more surfaces	Not A Benefit
D2710	Crown - resin (indirect)	\$150.00
D2720	Crown - resin with high noble metal	Not A Benefit
D2721	Crown - resin with predominantly base metal	\$220.00
D2722	Crown - resin with noble metal	Not A Benefit
D2740	Crown - porcelain/ceramic substrate	\$340.00
D2750	Crown - porcelain fused to high noble metal	Not A Benefit
D2751	Crown - porcelain fused to predominantly base metal	\$340.00
D2752	Crown - porcelain fused to noble metal	Not A Benefit
D2780	Crown - 3/4 cast high noble metal	Not A Benefit
D2781	Crown - 3/4 cast predominantly base metal	\$340.00
D2782	Crown - 3/4 cast noble metal	Not A Benefit
D2783	Crown - 3/4 porcelain/ceramic	\$340.00
D2790	Crown - full cast high noble metal	Not A Benefit
D2791	Crown - full cast predominantly base metal	\$340.00
D2792	Crown - full cast noble metal	Not A Benefit
D2799	Provisional crown	Not A Benefit

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D2910	Recement inlay	\$30.00
D2920	Recement crown	\$30.00
D2930	Prefabricated stainless steel crown - primary tooth	\$75.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$90.00
D2932	Prefabricated resin crown	\$75.00
D2933	Prefabricated stainless steel crown with resin window	\$75.00
D2940	Sedative filling	\$45.00
D2950	Core buildup, including any pins	Global
D2951	Pin retention - per tooth, in addition to restoration	\$80.00
D2952	Cast post and core in addition to crown	\$75.00
D2953	Each additional cast post - same tooth	Global
D2954	Prefabricated post and core in addition to crown	\$75.00
D2955	Post removal (not in conjunction with endodontic therapy)	Global
D2957	Each additional prefabricated post - same tooth	Global
D2960	Labial veneer (resin laminate) - chairside	Not A Benefit
D2961	Labial veneer (resin laminate) - laboratory	Not A Benefit
D2962	Labial veneer (porcelain laminate) - laboratory	Not A Benefit
D2970	Temporary crown (fractured tooth)	\$45.00
D2980	Crown repair, by report	\$60.00
D2999	Unspecified restorative procedure, by report	\$50.00

#### **Endodontics**

D2940	Sedative filling	\$45.00
D3110	Pulp cap - direct (excluding final restoration)	Global
D3120	Pulp cap - indirect (excluding final restoration)	Global
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction application of medicament	\$71.00
D3221	Pulpal debridement, primary and permanent teeth	\$45.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$71.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$71.00
D3310	Anterior (excluding final restoration)	\$216.00
D3320	Bicuspid (excluding final restoration)	\$261.00
D3330	Molar (excluding final restoration)	\$331.00
D3331	Treatment of root canal obstruction; non-surgical access	Global
D3332	Incomplete endodontic therapy; inoperable or fractured tooth	Not A Benefit
D3333	Internal root repair of perforation defects	Global
D3346	Retreatment of previous root canal therapy - anterior	\$216.00
D3347	Retreatment of previous root canal therapy - bicuspid	\$261.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D3348	Retreatment of previous root canal therapy - molar	\$331.00
D3351	Apexification/Recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$100.00
D3352	Apexification/Recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$100.00
D3353	Apexification/Recalcification - final visit (apical closure/calcific repair of perforations, root resorption, etc.)	Not A Benefit
D3410	Apicoectomy/Periradicular surgery - anterior	\$100.00
D3421	Apicoectomy/Periradicular surgery - bicuspid (first root)	\$100.00
D3425	Apicoectomy/Periradicular surgery - molar (first root)	\$100.00
D3426	Apicoectomy/Periradicular surgery - (each additional root)	\$100.00
D3430	Retrograde filling - per root	Global
D3450	Root amputation - per root	Not A Benefit
D3460	Endodontic endosseous implant	Not A Benefit
D3470	Intentional reimplantation (including necessary splinting)	Not A Benefit
D3910	Surgical procedure for isolation of tooth with rubber dam	Global
D3920	Hemisection (including any root removal), not including root canal therapy	Not A Benefit
D3950	Canal preparation and fitting of preformed dowel or post	Not A Benefit
D3999	Unspecified endodontic procedure, by report	\$42.00

#### **Periodontics**

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	\$185.00
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	\$110.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	Not A Benefit
D4241	Gingival flap procedure, including root planing - one to three teeth per quadrant	Not A Benefit
D4245	Apically positioned flap	Not A Benefit
D4249	Clinical crown lengthening - hard tissue	Not A Benefit
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	\$350.00
D4261	Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant	\$245.00
D4263	Bone replacement graft - first site in quadrant	Not A Benefit
D4264	Bone replacement graft - each additional site in quadrant	Not A Benefit
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Global
D4266	Guided tissue regeneration - resorbable barrier, per site	Not A Benefit
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	Not A Benefit
D4268	Surgical revision procedure, per tooth	Not A Benefit
D4270	Pedicle soft tissue graft procedure	Not A Benefit
D4271	Free soft tissue graft procedure (including donor site surgery)	Not A Benefit

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D4273	Subepithelial connective tissue graft procedures	Not A Benefit
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	Not A Benefit
D4275	Soft tissue allograft	Not A Benefit
D4276	Combined connective tissue and double pedicle graft	Not A Benefit
D4320	Provisional splinting - intracoronal	Not A Benefit
D4321	Provisional splinting - extracoronal	Not A Benefit
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	\$50.00
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	\$30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Global
D4381	Localized delivery of chemotherapeutic agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	Global
D4910	Periodontal maintenance	Not A Benefit
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$45.00
D4999	Unspecified periodontal procedure, by report	By Report

#### **Prosthodontics (Removable)**

D5110	Complete denture - maxillary	\$450.00
D5120	Complete denture - mandibular	\$450.00
D5130	Immediate denture - maxillary	\$450.00
D5140	Immediate denture - mandibular	\$450.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$250.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rest and teeth)	\$250.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	\$470.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	\$470.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	Not A Benefit
D5410	Adjust complete denture - maxillary	\$25.00
D5411	Adjust complete denture - mandibular	\$25.00
D5421	Adjust partial denture - maxillary	\$25.00
D5422	Adjust partial denture - mandibular	\$25.00
D5510	Repair broken complete denture base	\$50.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$50.00
D5610	Repair resin denture base	\$60.00
D5620	Repair cast framework	\$230.00
D5630	Repair or replace broken clasp	\$100.00
D5640	Replace broken teeth - per tooth	\$50.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D5650	Add tooth to existing partial denture	\$60.00
D5660	Add clasp to existing partial denture	\$100.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not A Benefit
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	Not A Benefit
D5710	Rebase complete maxillary denture	Not A Benefit
D5711	Rebase complete mandibular denture	Not A Benefit
D5720	Rebase maxillary partial denture	Not A Benefit
D5721	Rebase mandibular partial denture	Not A Benefit
D5730	Reline complete maxillary denture (chairside)	\$70.00
D5731	Reline complete mandibular denture (chairside)	\$70.00
D5740	Reline maxillary partial denture (chairside)	\$70.00
D5741	Reline mandibular partial denture (chairside)	\$70.00
D5750	Reline complete maxillary denture (laboratory)	\$140.00
D5751	Reline complete mandibular denture (laboratory)	\$140.00
D5760	Reline maxillary partial denture (laboratory)	\$140.00
D5761	Reline mandibular partial denture (laboratory)	\$140.00
D5810	Interim complete denture (maxillary)	Not A Benefit
D5811	Interim complete denture (mandibular)	Not A Benefit
D5820	Interim partial denture (maxillary)	Not A Benefit
D5821	Interim partial denture (mandibular)	Not A Benefit
D5850	Tissue conditioning, maxillary	\$50.00
D5851	Tissue conditioning, mandibular	\$50.00
D5860	Overdenture - complete, by report	\$450.00
D5861	Overdenture - partial, by report	Not A Benefit
D5862	Precision attachment, by report	Global
D5867	Replacement of replaceable part of semi-precision or precision attachment (male or female component)	Not A Benefit
D5875	Modification of removable prosthesis following implant surgery	Not A Benefit
D5899	Unspecified removable prosthodontic procedure, by report	By Report

#### **Maxillofacial Prosthetics**

D5911	Facial moulage (sectional)	\$425.00
D5912	Facial moulage (complete)	\$534.00
D5913	Nasal prosthesis	\$1,200.00
D5914	Auricular prosthesis	\$1,200.00
D5915	Orbital prosthesis	\$600.00
D5916	Ocular prosthesis	\$1,200.00
D5919	Facial prosthesis	\$1,200.00
D5922	Nasal septal prosthesis	\$600.00
D5923	Ocular prosthesis, interim	\$600.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D5924	Cranial prosthesis	\$1,400.00
D5925	Facial augmentation implant prosthesis	\$300.00
D5926	Nasal prosthesis, replacement	\$300.00
D5927	Auricular prosthesis, replacement	\$300.00
D5928	Orbital prosthesis, replacement	\$300.00
D5929	Facial prosthesis, replacement	\$300.00
D5931	Obturator prosthesis, surgical	\$1,000.00
D5932	Obturator prosthesis, definitive	\$1,500.00
D5933	Obturator prosthesis, modification	\$225.00
D5934	Mandibular resection prosthesis with guide flange	\$1,700.00
D5935	Mandibular resection prosthesis without guide flange	\$1,400.00
D5936	Obturator prosthesis, interim	\$900.00
D5937	Trismus appliance (not for TMD treatment)	\$125.00
D5951	Feeding aid	\$200.00
D5952	Speech aid prosthesis, pediatric	\$800.00
D5953	Speech aid prosthesis, adult	\$1,450.00
D5954	Palatal augmentation prosthesis	\$200.00
D5955	Palatal lift prosthesis, definitive	\$1,400.00
D5958	Palatal lift prosthesis, interim	\$800.00
D5959	Palatal lift prosthesis, modification	\$220.00
D5960	Speech aid prosthesis, modification	\$220.00
D5982	Surgical stent	\$125.00
D5983	Radiation carrier	\$80.00
D5984	Radiation shield	\$200.00
D5985	Radiation cone locator	\$200.00
D5986	Fluoride gel carrier	\$80.00
D5987	Commissure splint	\$125.00
D5988	Surgical splint	\$205.00
D5999	Unspecified maxillofacial prosthesis, by report	By Report

#### **Implant Services**

D6010	Surgical placement of implant body: endosteal implant	By Report
D6020	Abutment placement of substitution: endosteal implant	By Report
D6040	Surgical placement: eposteal implant	By Report
D6050	Surgical placement: transosteal implant	By Report
D6053	Implant/Abutment supported removable denture for completely edentulous arch	By Report
D6054	Implant/Abutment supported removable denture for partially edentulous arch	By Report
D6055	Dental implant supported connecting bar	By Report



CDT-4 Codes	Procedure Code Description	Maximum \$\$ Allowance
D6056	Prefabricated abutment	By Report
D6057	Custom abutment	By Report
D6058	Abutment supported porcelain/ceramic crown	By Report
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	By Report
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	By Report
D6061	Abutment supported porcelain fused to metal crown (noble metal)	By Report
D6062	Abutment supported cast metal crown (high noble metal)	By Report
D6063	Abutment supported cast metal crown (predominantly base metal)	By Report
D6064	Abutment supported cast metal crown (noble metal)	By Report
D6065	Implant supported porcelain/ceramic crown	By Report
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	By Report
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	By Report
D6068	Abutment supported retainer for porcelain/ceramic FPD	By Report
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	By Report
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	By Report
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	By Report
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	By Report
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	By Report
D6074	Abutment supported retainer for cast metal FPD (noble metal)	By Report
D6075	Implant supported retainer for ceramic FPD	By Report
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	By Report
D6078	Implant/Abutment supported fixed denture for completely edentulous arch	By Report
D6079	Implant/Abutment supported fixed denture for partially edentulous arch	By Report
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	By Report
D6090	Repair implant supported prosthesis, by report	By Report
D6095	Repair implant abutment, by report	By Report
D6100	Implant removal, by report	\$45.00
D6199	Unspecified implant procedure, by report	By Report
<b>Fixed Prosthodontics</b>		
D6210	Pontic - cast high noble metal	Not A Benefit
D6211	Pontic - cast predominantly base metal	\$325.00
D6212	Pontic - cast noble metal	Not A Benefit

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D6240	Pontic - porcelain fused to high noble metal	Not A Benefit
D6241	Pontic - porcelain fused to predominantly base metal	\$325.00
D6242	Pontic - porcelain fused to noble metal	Not A Benefit
D6245	Pontic - porcelain/ceramic	\$325.00
D6250	Pontic - resin with high noble metal	Not A Benefit
D6251	Pontic - resin with predominantly base metal	\$325.00
D6252	Pontic - resin with noble metal	Not A Benefit
D6253	Provisional pontic	Not A Benefit
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not A Benefit
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not A Benefit
D6600	Inlay - porcelain/ceramic, two surfaces	Not A Benefit
D6601	Inlay - porcelain/ceramic, three or more surfaces	Not A Benefit
D6602	Inlay - cast high noble metal, two surfaces	Not A Benefit
D6603	Inlay - cast high noble metal, three or more surfaces	Not A Benefit
D6604	Inlay - cast predominantly base metal, two surfaces	Not A Benefit
D6605	Inlay - cast predominantly base metal, three or more surfaces	Not A Benefit
D6606	Inlay - cast noble metal, two surfaces	Not A Benefit
D6607	Inlay - cast noble metal, three or more surfaces	Not A Benefit
D6608	Onlay - porcelain/ceramic, two surfaces	Not A Benefit
D6609	Onlay - porcelain/ceramic, three or more surfaces	Not A Benefit
D6610	Onlay - cast high noble metal, two surfaces	Not A Benefit
D6611	Onlay - cast high noble metal, three or more surfaces	Not A Benefit
D6612	Onlay - cast predominantly base metal, two surfaces	Not A Benefit
D6613	Onlay - cast predominantly base metal, three or more surfaces	Not A Benefit
D6614	Onlay - cast noble metal, two surfaces	Not A Benefit
D6615	Onlay - cast noble metal, three or more surfaces	Not A Benefit
D6720	Crown - resin with high noble metal	Not A Benefit
D6721	Crown - resin with predominantly base metal	\$220.00
D6722	Crown - resin with noble metal	Not A Benefit
D6740	Crown - porcelain/ceramic	\$340.00
D6750	Crown - porcelain fused to high noble metal	Not A Benefit
D6751	Crown - porcelain fused to predominantly base metal	\$340.00
D6752	Crown - porcelain fused to noble metal	Not A Benefit
D6780	Crown - 3/4 cast high noble metal	Not A Benefit
D6781	Crown - 3/4 cast predominantly base metal	\$340.00
D6782	Crown - 3/4 cast noble metal	Not A Benefit
D6783	Crown - 3/4 porcelain/ceramic	\$340.00
D6790	Crown - full cast high noble metal	Not A Benefit
D6791	Crown - full cast predominantly base metal	\$340.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D6792	Crown - full cast noble metal	Not A Benefit
D6793	Provisional retainer crown	Not A Benefit
D6920	Connector bar	Not A Benefit
D6930	Recement fixed partial denture	\$50.00
D6940	Stress breaker	Not A Benefit
D6950	Precision attachment	Not A Benefit
D6970	Cast post and core in addition to fixed partial denture retainer	\$75.00
D6971	Cast post as part of fixed partial denture retainer	\$75.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$75.00
D6973	Core build up for retainer, including any pins	Global
D6975	Coping - metal	Not A Benefit
D6976	Each additional cast post - same tooth	Global
D6977	Each additional prefabricated post - same tooth	Global
D6980	Fixed partial denture repair, by report	\$75.00
D6985	Pediatric partial denture, fixed	Not A Benefit
D6999	Unspecified fixed prosthodontic procedure, by report	By Report

#### **Oral and Maxillofacial Surgery**

D7111	Coronal remnants - deciduous tooth	\$41.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$41.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$85.00
D7220	Removal of impacted tooth - soft tissue	\$100.00
D7230	Removal of impacted tooth - partially bony	\$135.00
D7240	Removal of impacted tooth - completely bony	\$165.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$235.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$100.00
D7260	Oroantral fistula closure	\$300.00
D7261	Primary closure of a sinus perforation	\$100.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$175.00
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization)	Not A Benefit
D7280	Surgical access of an unerupted tooth	\$100.00
D7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$135.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	Not A Benefit
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$100.00
D7286	Biopsy of oral tissue - soft (all others)	\$30.00
D7287	Cytology sample collection	Not A Benefit
D7290	Surgical repositioning of teeth	\$135.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$50.00
D7310	Alveoloplasty in conjunction with extractions - per quadrant	\$50.00
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	\$100.00
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$200.00
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$500.00
D7410	Excision of benign lesion up to 1.25 cm	\$100.00
D7411	Excision of benign lesion greater than 1.25 cm	\$250.00
D7412	Excision of benign lesion, complicated	\$325.00
D7413	Excision of malignant lesion up to 1.25 cm	\$325.00
D7414	Excision of malignant lesion greater than 1.25 cm	\$400.00
D7415	Excision of malignant lesion, complicated	\$450.00
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	\$325.00
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	\$500.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$100.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$200.00
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$100.00
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$250.00
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$50.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$100.00
D7472	Removal of torus palatinus	\$200.00
D7473	Removal of torus mandibularis	\$100.00
D7485	Surgical reduction of osseous tuberosity	\$75.00
D7490	Radical resection of mandible with bone graft	\$1,200.00
D7510	Incision and drainage of abscess - intraoral soft tissue	\$50.00
D7520	Incision and drainage of abscess - extraoral soft tissue	\$75.00
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$60.00
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$130.00
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$100.00
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$380.00
D7610	Maxilla - open reduction (teeth immobilized, if present)	\$1,000.00
D7620	Maxilla - closed reduction (teeth immobilized, if present)	\$500.00
D7630	Mandible - open reduction (teeth immobilized, if present)	\$1,200.00
D7640	Mandible - closed reduction (teeth immobilized, if present)	\$700.00
D7650	Malar and/or zygomatic arch - open reduction	\$500.00
D7660	Malar and/or zygomatic arch - closed reduction	\$250.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D7670	Alveolus - closed reduction, may include stabilization of teeth	\$225.00
D7671	Alveolus - open reduction, may include stabilization of teeth	\$275.00
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7710	Maxilla - open reduction	\$1,200.00
D7720	Maxilla - closed reduction	\$800.00
D7730	Mandible - open reduction	\$1,200.00
D7740	Mandible - closed reduction	\$800.00
D7750	Malar and/or zygomatic arch - open reduction	\$500.00
D7760	Malar and/or zygomatic arch - closed reduction	\$250.00
D7770	Alveolus - open reduction stabilization of teeth	\$1,000.00
D7771	Alveolus, closed reduction stabilization of teeth	\$500.00
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	By Report
D7810	Open reduction of dislocation	\$140.00
D7820	Closed reduction of dislocation	\$140.00
D7830	Manipulation under anesthesia	\$140.00
D7840	Condylectomy	\$1,000.00
D7850	Surgical discectomy, with/without implant	\$1,000.00
D7852	Disc repair	\$780.00
D7854	Synovectomy	\$800.00
D7856	Myotomy	\$810.00
D7858	Joint reconstruction	\$1,550.00
D7860	Arthrotomy	\$940.00
D7865	Arthroplasty	\$1,100.00
D7870	Arthrocentesis	\$440.00
D7871	Non-arthroscopic lysis and lavage	Global
D7872	Arthroscopy - diagnosis, with or without biopsy	\$800.00
D7873	Arthroscopy - surgical: lavage and lysis of adhesions	\$800.00
D7874	Arthroscopy - surgical: disc repositioning and stabilization	\$800.00
D7875	Arthroscopy - surgical: synovectomy	\$800.00
D7876	Arthroscopy - surgical: discectomy	\$1,000.00
D7877	Arthroscopy - surgical: debridement	\$800.00
D7880	Occlusal orthotic device, by report	\$300.00
D7899	Unspecified TMD therapy, by report	By Report
D7910	Suture of recent small wounds up to 5 cm	\$75.00
D7911	Complicated suture - up to 5 cm	\$85.00
D7912	Complicated suture - greater than 5 cm	\$95.00
D7920	Skin graft (identify defect covered, location and type of graft)	\$310.00
D7940	Osteoplasty - for orthognathic deformities	\$1,300.00

CDT-4 Codes	Procedure Code Description	Maximum \$\$ Allowance
D7941	Osteotomy - mandibular rami	\$2,000.00
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	\$2,800.00
D7944	Osteotomy - segmented or subapical - per sextant or quadrant	\$600.00
D7945	Osteotomy - body of mandible	\$600.00
D7946	LeFort I (maxilla - total)	\$1,300.00
D7947	LeFort I (maxilla - segmented)	\$2,000.00
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	\$2,300.00
D7949	LeFort II or LeFort III - with bone graft	\$3,000.00
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report	\$800.00
D7955	Repair of maxillofacial soft and hard tissue defect	By Report
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$200.00
D7970	Excision of hyperplastic tissue - per arch	\$100.00
D7971	Excision of pericoronal gingiva	\$50.00
D7972	Surgical reduction of fibrous tuberosity	\$50.00
D7980	Sialolithotomy	\$235.00
D7981	Excision of salivary gland, by report	\$521.00
D7982	Sialodochoplasty	\$365.00
D7983	Closure of salivary fistula	\$120.00
D7990	Emergency tracheotomy	\$200.00
D7991	Coronoidectomy	\$558.00
D7995	Synthetic graft - mandible or facial bones, by report	\$335.00
D7996	Implant - mandible for augmentation purposes (excluding alveolar ridge), by report	Not A Benefit
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	\$45.00
D7999	Unspecified oral surgery procedure, by report	By Report

#### Orthodontics

D8010	Limited orthodontic treatment of the primary dentition	Not A Benefit
D8020	Limited orthodontic treatment of the transitional dentition	Not A Benefit
D8030	Limited orthodontic treatment of the adolescent dentition	Not A Benefit
D8040	Limited orthodontic treatment of the adult dentition	Not A Benefit
D8050	Interceptive orthodontic treatment of the primary dentition	Not A Benefit
D8060	Interceptive orthodontic treatment of the transitional dentition	Not A Benefit
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not A Benefit
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Handicapping malocclusion</i>	\$750.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Cleft palate - primary dentition</i>	\$425.00

CDT-4 Codes	Procedure Code Description	Maximum \$\$ Allowance
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Cleft palate - mixed dentition</i>	\$625.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Cleft palate - permanent dentition</i>	\$925.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Facial growth management - primary dentition</i>	\$425.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Facial growth management - mixed dentition</i>	\$625.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition <i>Facial growth management - permanent dentition</i>	\$1,000.00
D8090	Comprehensive orthodontic treatment of the adult dentition	Not A Benefit
D8210	Removable appliance therapy	\$245.00
D8220	Fixed appliance therapy	\$245.00
D8660	Pre-orthodontic treatment visit	\$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Handicapping malocclusion</i>	\$70.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Cleft palate - primary dentition</i>	\$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Cleft palate - mixed dentition</i>	\$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Cleft palate - permanent dentition</i>	\$100.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Facial growth management - primary dentition</i>	\$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Facial growth management - mixed dentition</i>	\$50.00
D8670	Periodic orthodontic treatment visit (as part of contract) <i>Facial growth management - permanent dentition</i>	\$100.00
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$244.00
D8690	Orthodontic treatment (alternative billing to a contract fee)	Not A Benefit
D8691	Repair of orthodontic appliance	\$50.00
D8692	Replacement of lost or broken retainer	\$200.00
D8999	Unspecified orthodontic procedure, by report	By Report

#### Adjunctives

D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$45.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$45.00
D9211	Regional block anesthesia	Global
D9212	Trigeminal division block anesthesia	Global
D9215	Local anesthesia	Global
D9220	Deep sedation/general anesthesia - first 30 minutes	\$127.00

<b>CDT-4 Codes</b>	<b>Procedure Code Description</b>	<b>Maximum \$\$ Allowance</b>
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$63.00
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	\$25.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$100.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$30.00
D9248	Non-intravenous conscious sedation	\$25.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	Global
D9410	House/Extended care facility call	\$20.00
D9420	Hospital call	\$50.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$20.00
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	Not A Benefit
D9610	Therapeutic drug injection, by report	\$15.00
D9630	Other drugs and/or medicaments, by report	Not A Benefit
D9910	Application of desensitizing medicament	\$43.00
D9911	Application of desensitizing resin for cervical and/or root surface, per tooth	Not A Benefit
D9920	Behavior management, by report	Not A Benefit
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$15.00
D9940	Occlusal guard, by report	Not A Benefit
D9941	Fabrication of athletic mouthguard	Not A Benefit
D9950	Occlusion analysis - mounted case	\$180.00
D9951	Occlusal adjustment - limited	\$25.00
D9952	Occlusal adjustment - complete	\$400.00
D9970	Enamel microabrasion	Not A Benefit
D9971	Odontoplasty 1-2 teeth; includes removal of enamel projections	Not A Benefit
D9972	External bleaching - per arch	Not A Benefit
D9973	External bleaching - per tooth	Not A Benefit
D9974	Internal bleaching - per tooth	Not A Benefit
D9999	Unspecified adjunctive procedure, by report	By Report